THERAPEUTIC MEASURES FOR SURVIVING SPOUSES

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We hereby recommend that the Thesis prepared under our supervision by Rebecca J. Ragland Cherry B.S. entitled "Therapeutic Measures for Surviving Spouses"

be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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CHAPTER I

Introduction

Death is a constant, universal phenomenon. In Western culture, however, death is no longer viewed nor accepted as the natural course in man's life cycle. The majority of deaths occur in the hospital setting, thus isolating the general society from death and its effects on the survivors. Avoidance of death has become a common and socially accepted practice.

Despite everyday associations with death, health care professionals have a tendency to shun the responsibility of dealing with dying patients and grieving survivors on a person-to-person level. This can be observed by the technical postures the nurse, physician, and other medical personnel often assume to avoid an emotionally painful interaction. Often details such as removing the body from sight of other patients, making arrangements for an autopsy, or completing reports of the death to be submitted to supervisors are given priority over offering supportive measures to the grieving family.

It has only been in the last two decades that the problem of inadequate support for grieving persons has

been recognized and attempts have been initiated to remedy it. Authorities on the subject of grief have identified measures that help the bereaved person begin coping with the overwhelming stress precipitated by the loss of a loved one. Medical and Nursing programs are beginning to emphasize the need for and the utilization of therapeutic measures to aid the dying patient and his family.

However, one aspect of this problem has not been studied extensively and may have much bearing on the ability of health team personnel to provide supportive measures to the grieving family: it is the relationship of sex roles to the avoidance of helping the grieved. It has been observed that a female nurse will initiate contact with a new widow. Some supportive measures are provided and in most cases, readily accepted. However, the opposite has been observed with the new widower. The female nurse will not encourage a widower to express his feelings, and may even show embarrassment or disgust if he does show emotion. The extent of the nurse's comforting may be an offer to call the chaplain or provide a cup of coffee.

This study attempts to answer questions about measures the female nurse uses in working with grieving

spouses and about observed differences in the nurse's interaction with widows and widowers in the immediate grief period.

Statement of Problem

The problem of this study was to determine whether or not there is a difference in measures the female nurse perceives as therapeutic and actually uses in dealing with the widow and the widower in the immediate grief state.

Purposes

The purposes of this study were:

1. To identify measures the female nurse perceives therapeutic in dealing with the widow in the immediate grief state.

2. To identify measures the female nurse employs in dealing with the widow in the immediate grief state.

3. To determine if there is a difference in the measures the female nurse perceives therapeutic and the measures she actually uses in working with the widow in the immediate grief state.

4. To identify measures the female nurse perceives therapeutic in dealing with the widower in the immediate grief state.

5. To identify measures the female nurse employs in dealing with the widower in the immediate grief state

6. To determine if there is a difference in the measures the female nurse perceives therapeutic and the measures she actually uses in working with the widower in the immediate grief state.

7. To determine if there is a difference in the measures the female nurse perceives therapeutic in dealing with the widow and the measures she perceives therapeutic in dealing with the widower in the immediate grief state.

8. To determine if there is a difference in the measures the female nurse uses in working with widows and the measures she uses in working with widowers in the immediate grief state.

Background Significance

Nearly two thirds of the two million people that will die this year in the United States will die in hospitals. The environment within which living and dying occurs has shifted from the home to the hospital (Day 1972). Health care personnel are now the ones who are most often confronted with the management of the dying person and his family, yet the ability of the health care team to be therapeutic at such a time is sporadic and inconsistent (Fulton et al. 1964).

This inadequacy in management of the death process has been studied by various psychologists, sociologists, and

medical practitioners (Fiefel 1943; Fulton 1972; Glaser and Strauss 1966; Kubler-Ross 1974; Quint 1967; Spitzer 1964; and Wahl 1958). Authorities note that death itself is a taboo subject in the United States (Fiefel 1943; Quint 1967; and Tillich 1959). Tillich (1959) suggests that some ways the American culture supports the denial of death can be viewed in its social practices. It is a social taboo to choose death as a general topic of conversation. In children's literature, the hero usually returns to life, thus denying the permanence of death. The funeral industry attempts to immortalize the corpse by use of clothing and cosmetics so that it appears "alive."

The isolation of death from society has shielded children from personal encounters with the death and grief process. Thus, the twentieth century American reaches adulthood with little opportunity to view death as a natural pehnomenon and to participate in the mourning process (Quint 1967).

"Scientists and professional people are no less immune to prejudices concerning death than other groups" (Fiefel 1943 p. 15). Much of this prejudice is associated with the traditional educational focus of health professions. Psychological care of the dying patient and the survivors has not been included in the curricula of nursing schools until the last ten years. This trend is

also reflected in nursing journals which upon examination reveal few articles on the subject of death and grief until the early 1960's. Since that time, many articles have been published concerning death and the grief process (Quint 1967). Thus, many nurses who completed their education before this time have had little or no formal education and training in working with survivors.

Beland (1970) also attributes much of this prejudice to the emphasis on cure as the primary objective of the health profession. Cure is considered a measure of success, and therefore death is viewed as failure (Beland 1970; Day 1972; and Glaser and Strauss 1964).

Kubler-Ross (1974) notes that medical staff caring for a dying person frequently must go through the grief process as they become involved with their patients. Thus, the avoidance of death is identified by Engel (1964) as a measure of self-protection from repeated exposure to emotionally painful situations. Kutscher (1971) states:

> Abandonment of the bereaved should be recognized for what it is: for the professional and paramedical personnel it is a retreat from their own unresolved conflicts concerning death (p. 285).

The nurse may not understand the grief process as a result of exclusion of this subject from her formal nursing education. Understanding the grief process is necessary to begin correcting this inadequacy in dealing with the

survivors of a dying patient (Day 1972). Engel (1964) identifies grief as a "typical reaction to the loss of a source of psychological gratification" (p. 280). Separation anxiety is the central dynamic of grief (Switzer 1970). Taplin (1971) defines grief as a crisis: "An intense experience" which pressures the individual to seek some form of resolution.

The roles males and females assume in Western culture also influence the manner and degree of interaction with grieving persons. Socially prescribed roles associated with one's gender are learned at an early age and reinforced throughout one's life (Shope 1975). A role provides the expectations which guide appropriate conduct in a given situation (Corwin 1962).

Males are taught an "instrumental role" which requires them to perform tasks without display of feelings (Jourard 1964). However, in the Western culture, people are expected to express grief when faced with the loss of a loved one (Fulton 1965). Thus, an ambivalent situation arises in which society prohibits the male from showing emotion yet at the same time, requires him to express the depth of his loss (Fulton 1965). As a result of this role conflict, the male is unsure of the appropriate emotional response. This conflict is also felt among persons

involved with the grieving male and is manifested in their avoidance of him (Kubler-Ross 1969).

Females assume an "expressive role" in Western culture (Jourard 1964). Society allows a female to cry, show anger, or be depressed. Therefore, when a female loses a loved one, it is socially permissible for her to display a certain amount of emotion and those around her feel relatively comfortable with this expected behavior (Switzer 1970).

The manner in which males and females interact is also dictated by social mores and roles. Jourard (1971) noted that touch and proximity between the sexes varied. Males were touched in different body zones and with different frequency than were females. Touch between male and female (excluding child-parent situations) is generally given sexual connotation in Western culture. The distance maintained between persons also carries meaning (Jourard 1971). Emotional detatchment is conveyed by physical distance. Males and females learn to interact within this context when any new situation is encountered.

Harlow (1958) in his studies with monkeys and surrogate "mothers" of terry cloth, found contact to be the major source of comfort when the monkeys were frightened or stressed. Harlow hypothesizes that physical contact may be the natural or primordial source of comfort. If

contact is indeed a major source of comfort, then again an ambivalent situation may arise when one is faced with comforting a grieving person of the opposite sex. Contact may be withheld for fear the encounter will be incorrectly perceived.

Cultural attitudes, goals of the profession, lack of knowledge about the grief process, inner conflicts or fears about death, and behavior dictated by sex roles may all contribute to the nurse's inadequacies in dealing with death and the grieving family. The need to remedy this situation is paramount. Prolonged or maladaptive effects of grief have been studied extensively. Kutscher (1971) and Parkes (1964) believe grief should be treated as an illness. Just as illness responds to treatment more rapidly in its earliest stages, so does bereavement. Extensive physical and psychological damage may occur if grief is prolonged (Krant 1975).

Marshal (1969) discussed the development of pathology which rises from the mourner's inability to express his feelings. Parkes, Benjamin, and Fitzgerald (1969) studied the mortality rate of widowers during the first six months of bereavement. The mortality rate was found to be 40 percent above the expected rate for married men of the same age. A study by Parkes and Brown (1972)

showed a marked increase in somatic symptoms of widows and widowers.

A grieving person has two basic needs: (1) to be with the dying person and to be aware of his condition, and (2) to ventilate his emotions and receive comfort (Hampe 1975). Because the majority of deaths are occurring in the hospital setting, health care personnel should assume a major role in meeting these needs and in promoting adaptive grief work. Measures have been identified which help the grieved begin to cope with the intense emotions felt following the death of a loved one.

Beachy (1967), Day (1972), Engel (1964), Kubler-Ross (1974), Lindemann (1963), Marshall (1969), Switzer (1970), and Wygant (1967) agree that outward expression of feelings is necessary to facilitate the work of grieving. Emotional expression, especially crying, should be encouraged. Switzer (1970) states that speech follows crying as an outlet for emotion. Encouraging the bereaved to talk about the loss is necessary. Holding the grieving person's hand or putting an arm around his shoulder conveys acceptability and comfort (Hein 1973). Remaining with the grief stricken to show concern is important (Marshall 1969; and Wygant 1967). Marshall also sees the necessity in discussing the grief process with the mourner so that he is reassured that this "disorganization" is temporary.

Switzer (1970) feels that a basic need of the grieved person is to have a positive attitude toward himself. This positive self-image can be reestablished by assuring the survivor that feelings of hostility and guilt are "normal" and acceptable at this time. Glaser and Strauss (1968) and Kubler-Ross (1974) believe that the "last look" and "last touch" must be allowed in order that the stage of awareness emerges. Providing religious comfort through the chaplain or minister is also cited as being therapeutic (Beachy 1967; Reeves 1970; and Sweetser 1975). Meeting basic physical needs of the survivor is essential. Providing food, beverages or physical rest show concern and are medically important for anyone under stress (Hammons 1971). During this immediate grief state the survivor is often incapable of making simple decisions or carrying out simple tasks. It is helpful to call a friend or relative to assist the survivor (Hammons 1971).

The grief process can be directed to adaptive behavior by employing these various universal measures promptly, following the death of the loved one. Nurses and other medical personnel continue to be ineffective in managing grief in the initial state (Quint 1967). It may be the result of negative social programming (Fiefel 1943; and Fulton et al. 1964) or the inability to resolve personal conflicts (Engel 1964; and Kutscher 1971). Perhaps the

barrier of sex roles interferes with the nurse's ability to be therapeutic at such a time (Jourard 1964). Whatever the reason(s), nurses and other health team members cannot continue to avoid the responsibility of helping any person who has just experienced the death of a loved one.

Hypotheses

The hypotheses of this study were:

1. There is no difference in the measures the female nurse perceives therapeutic and the measures she actually uses in dealing with the widow in the immediate grief state.

2. There is no difference in the measures the female nurse perceives therapeutic and the measures she actually uses in dealing with the widower in the immediate grief state.

3. There is no difference in the measures the female nurse perceives therapeutic in dealing with the widow and the measures she perceives therapeutic in dealing with the widower in the immediate grief state.

4. There is no difference in the measures the female nurse uses in dealing with the widow and the measures she uses in dealing with the widower in the immediate grief state.

Definition of Terms

Widow: A woman who has experienced the death of her present spouse.

Widower: A man who has experienced the death of his present spouse.

Nurse: A female who is currently licensed to practice professional nursing in the state of Texas. This includes graduates from two, three, four, or five year educational programs.

Grief: A complex combination of intense emotions which are expressed as a typical reaction to the death of a spouse. Mourning and bereavement are other words which mean grief.

Immediate Grief State: That time period immediately following the death of a spouse in the hospital in which the nurse has contact with the grieved. This period usually lasts from one to two hours following the death of the patient and usually includes the stages of shock and disbelief and a growing awareness of the reality of the situation.

Therapeutic Measures: Any measure the nurse knows and/or uses which helps a spouse cope with the intense feelings in the immediate grief state and help that person begin a healthy adaptation to the loss of their loved one.

Sex Roles: Cultural mores that describe behavior to be conducted by males and females.

Limitations

The limitations of this study were as follows:

1. The amount of experience in working with surviving spouses in the immediate grief state may have varied among the respondants.

2. Interactions with grieving spouses may have been affected by the nurse's personal identification with the grief situation.

3. The amount of formal education varied among the respondants.

4. The amount of formal education the nurse had on the grief process was an uncontrolled variable in this study.

5. The nurse may not have accurately recalled the situation as it occurred.

Delimitations

The delimitations of this study were as follows:

1. For inclusion in this study all subjects were female.

2. All participants were registered nurses, currently licensed to practice in the State of Texas.

3. Each nurse had to be able to comprehend and express herself in the English language.

4. The nurse must have had at least one experience within the last 12 months in dealing with a widow or a widower in the immediate grief state.

5. The interaction with the widow or widower must have occurred in the hospital setting.

Assumptions

The assumptions considered basic to this study were as follows:

1. A person will experience grief upon the death of his/her spouse.

2. There are measures that are supportive to the bereaved person in the immediate grief period which will facilitate resolution of the loss.

3. A nurse has attitudes about death which are formed by her culture, religion, education, and life experiences.

Summary

Research into the interaction between health care personnel and bereaved persons is increasing as knowledge about the physical and psychological complications of grief emerges. A difference in the manner in which a nurse interacts with grieving males and females has been observed but there is little or no documentation of this observed difference. The primary purpose of this study was to document whether or not there indeed is a difference in

the way a female nurse relates to a widow and the way she relates to a widower in the immediate grief period.

Chapter II of this study is concerned with reviewing the literature pertinent to: cultural attitudes about death, factors in the avoidance of death and grief, relationship of sex roles to grief interactions, discussions on the stages of grief, studies conducted on the effects of grief, and supportive measures for a newly widowed person. Chapter III describes: (1) the setting in a large Central Texas hospital and population of registered nurses for the study, (2) development and validation of the tool used to study the nurse's support of the bereaved spouse in the immediate grief state, (3) procedure for collecting the data, and (4) usage of the Chi Square and McNemar tests of significance for the analysis of the data. Chapter IV contains a description of the sample population and presents a statistical analysis of the data obtained and a summary of significant findings. Chapter V summarizes and presents conclusions from the study, discusses implications and offers recommendations for further study.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The study of the nurse's perception and use of therapeutic measures in working with a newly widowed person in the immediate grief stage involved the investigation of several areas of the literature. These areas included: Factors, including sex role behavior, that affect the avoidance of death and grief; stages of grief; complications and abnormal reactions of grief; and therapeutic measures for a person in the immediate grief state.

Attitudes Toward Death

Last year, nearly two million people died in the United States (Monthly Vital Statistics Report, Feb. 1977). Approximately two thirds of these deaths occurred in hospitals or similar institutions. Thus, if there were but one person to mourn each death that occurred in the hospital setting, health care personnel around the nation encountered almost one and a half million deeply grieved people.

With the largest proportion of deaths occurring in hospitals, it would seem essential that health care personnel assume the responsibility for meeting the emotional needs of dying patient and his family. However, studies by Glaser and Strauss (1966, 1968), Kubler-Ross (1969), Mervyn (1971), Quint (1967), and Spitzer and Folta (1964) show that health care personnel frequently avoid this task.

Concern about this avoidance of the dying patient and his family has stimulated interest in educating health care personnel about the psycho-social needs of such patients (Day 1972; Kubler-Ross 1969; and Quint 1967). This increasing concern is evidenced in the number of recent medical, nursing, and social publications and articles written on the psychological aspect of dying and grief (Quint 1967). The National Academy of Sciences Institute of Medicine now sponsors studies on death and dying. A Foundation of Thanatology was formed in 1968 which sponsors international symposiums on the care of the dying, publishes textbooks on this subject, produces films on the topic of dying and grief, and plans to survey curricula in medical schools, nursing schools, and theological seminaries (Doyle 1972).

Despite efforts by those interested in this topic, health care personnel continue exhibiting avoidance of the dying patient and his grieving family. Western culture's views on death, individual conflicts and fears of death,

male/female roles in Western culture, lack of knowledge on the subject of death and grief, and the primary focus of cure of the health professions are major factors that lend to this problem.

Western Culture

Much of the avoidance of death has been attributed to the manner in which Western culture views death. Attitude formation about death has been a traditional function of its religions (Fulton and Langton 1964). Many religious rituals, such as the wake, were carried out at the time of death to perform three functions: (1) to support the grieving, (2) to approve the renunciation of what was lost, and (3) to guide in redefinition and reinvestment of self (Reeves 1970).

In the last thirty years, the technological explosion which has engulfed the Western culture has replaced theological practices and explanations about death with scientific rationales. Thus, the core for attitude and value formation about life and death has changed (Aries 1974; Elam 1969; Fulton and Langton 1964; Kubler-Ross 1969; Pattison 1974; Reeves 1970; and Scott 1971). When religious attitudes prevailed, death was simply explained as "natural and preordained" (Fulton and Langton 1964). Science has become able to explain and control many facets

of life that previously had been unquestioned and labeled "unchangeable" (Scott 1971). Medical technology is now able to prolong life through organ transplants, administration of potent drugs, and by the use of life sustaining machines (Pattison 1974). Because of such scientific advancements, Western societies have come to feel "invulnerable" to death rather than view death as an inevitable phenomenon (Scott 1971). When a death occurs, it is viewed as an "ultimate catastrophe" and not as a natural end to life (Elam 1969).

The general attitude of denying death is reflected in many of the social practices that surround death. The most obvious is the practice of isolating the dying from society by (1) hospitalization of the terminally ill, (2) placing the elderly in special nursing homes, and (3) conducting funerals in private funeral homes rather than in public churches (Aries 1974; Fulton and Langton 1964; and Tillich 1959). Practices of the funeral industry also reflect this denial of the reality of death (Aries 1974; Kubler-Ross 1969; and Tillich 1959). Corpses are embalmed, colored, and dressed in "sleeping clothes" to give a life-like appearance. Rooms in which the bodies are viewed are called "Slumber Rooms." At the gravesite, a casket is never lowered and buried until the funeral party adjourns (Aries 1974).

Attitudes about death are also reflected in the euphemisms that are used to describe death (Aries 1974; Fulton and Langton 1964; Kubler-Ross 1969; and Tillich 1959). Such terms as "passed on," "gone to heaven," and "kicked the bucket" are heard in substitution for death. Children's literature where the hero returns to life, placement of the obituary column in back pages of newspapers, and the absence of dying as a conversation topic are also reflections of Western culture attitudes on death (Tillich 1959).

Because death is so separated from society, few people have had personal encounters with death and the mourning process until adulthood (Quint 1967). Modern man without a "secular rationale to replace the traditional sacred view of death" (Fulton and Langton 1964, p. 109) and without childhood experience about death is left manifesting "acute anxiety about the prospect of death" and associated grieving processes (Scott and Howard 1971, p. 19).

Personal Conflicts and Fears

The consequent inner conflicts and fears about death lend to medical personnel's avoidance of dying people and those grieving the death. Howard and Scott (1971) state: "The fear of dying seems universal" (p. 16). One's presence in a situation where a death is about to, or has occurred serves to remind the individual of his own mortality (Choron 1964; Mervyn 1971). Kubler-Ross (1974)

states that when working with a dying patient and his family, medical personnel often become emotionally involved and grieve with and for their patient. They seek to find an explanation and cannot so they retreat from similar situations to escape additional emotional trauma (Engel 1964 and Kubler-Ross 1974). Thus, one may avoid the dying and the grieving because he has not resolved inner conflicts about his own death and the deaths of others around him (Kubler-Ross 1969; and Kutscher 1971).

Sex Roles

Another aspect of the problem involving the avoidance of the dying person and his family is derived from the roles males and females assume when interacting with others (Fulton 1965; and Switzer 1970). Western culture sex roles often create ambivalence in grief situations.

Males function in an "instrumental role" in Western society (Jourard 1964). Men are oriented toward performing tasks within the family structure and in the job setting (Steinmann and Fox 1974). Packard (1968) suggests this task orientation is not only an influence of tradition but also as result of biological factors. Certain characteristics are attributed to males such as aggression, dominance, strength, fearlessness, and independence (Shope 1975).

Females assume an "expressive role" in Western culture (Jourard 1964). This role evolved from the

biological function of bearing and nurturing children (Steinmann and Fox 1974). In this nurture role, the female learned to interact and relate with others by developing superior verbal fluency (Tyler 1965); by developing an ability to predict emotional responses; and by being allowed to express emotional tension (Packard 1968). The female was dependent on the male for food and shelter. Consequently, the characteristics of dependence, submissiveness, emotions, and family-centeredness have been attributed to femininity (Shope 1975).

In Western culture, it is not acceptable for a male to express emotion lest he display traits of "femininity" (Shope 1975). On the contrary, females are allowed and even expected to display emotion in dramatic life situations. It is important to understand this role differentiation in studying the nurse-patient interaction in the immediate grief period. In grief situations, males are expected to "mask their emotions of sorrow" (Switzer 1970). Jourard (1964) states:

> The male role, and the male's self-structure will not allow man to acknowledge or to express the entire breadth and depth of his inner experience, to himself or to others. Man seems obliged, rather, to hide much of his real self...the ongoing flow of his spontaneous inner experience...from himself and from others (p. 47).

Lack of emotional expression is often a reflection of masculine role acculturation rather than a reflection of

inward feeling. Therefore, Beachy (1967) warns that unverbalized grief is usually, nonetheless, present and may require more attention than grief which is readily expressed.

The manner in which one interacts with the grieving person is also dictated by whether you are a male or a female and by the gender of the grieving person. Cross-gender interactions can be mistakenly perceived as sexual contacts (Jourard 1971). Thus to avoid such misperceptions, one may completely avoid such an interaction.

Focus of Health Professions

The avoidance of the dying patient and his family may also be greatly influenced by the strong focus on cure as the primary objective of health professions (Glaser and Strauss 1968; Kubler-Ross 1969; Mervyn 1971; and Quint 1967). Beland (1970) states:

> In defining their role, patient, nurse, and physician all emphasize cure as an important criterion of success. When a patient recovers, nurses as well as doctors take credit for the patient's success... When they (patients) do not recover or they die, the nurse and/or doctor feels that he must have failed in some respect. (p. 66)

Because of the strong emphasis on cure and life, traditionally nursing and medical schools have not prepared their graduates to work with the dying patient and his family (Day 1972; and Quint 1967). Good (1972) states:

"Physicians trained to hate death, conditioned to fear and shun death, are often ill prepared to fulfill the roles demanded of them." (p. 24) Quint states:

> That many staff nurses in hospitals feel ill prepared to cope with problems of dying patients, and derive little personal satisfaction from these assignments, suggests that schools of nursing have provided insufficient training... particularly in the "hows" of performing the delicate psychological tasks associated with the dying process. (p. 10)

Glaser and Strauss (1968) note that it is essential for health care personnel to be educated about the grief process in order to meet the emotional needs of the dying patient and his family.

Stages of Grief

Grief is a process that occurs when a person loses something or someone meaningful to him (Buxbaum 1974; Engel 1964; Kubler-Ross 1969; Lindemann 1963; Switzer 1970; and Westberg 1962). A person may grieve when he loses a job, when a part of his body is surgically removed, when he learns of his impending death, or when a loved one dies (Kubler-Ross 1969; Marshall 1969; and Westberg 1962). Engel (1964) identifies grief as a "universal phenomenon among human beings" (p. 93). Many experts on grief maintain that it is a normal process and follows an orderly progression necessary in the adjustment to the death of loved ones (Mills 1969). This process of adjustment is often referred

to as "grief work." There is no general consensus among thanatologists on the length of time necessary to complete grief work. There is also some disagreement about the treatment of grief. A number of thanatologists believe grief should be treated as a healthy emotional process (Buxbaum 1975; Kubler-Ross 1969; and Westberg 1962). Others believe grief should not be viewed as a normal process but rather as a medical problem and treated as an illness (Benjamin, Parkes and Fitzgerald 1969; Brown and Parkes 1972; Krant 1975; and Maddison and Raphael 1973).

Engel (1964) identifies a sequence of events which characterize normal grief. The first phase is that of shock and disbelief. All studies agree that this is the first response to the death of a loved one (Pincus 1974). The initial response to hearing of the death is often "No! I don't believe it!" Frequently this is followed by feelings of numbness and the grief-stricken does not allow himself to think about the death. Engel (1964) labels this behavior as an "attempt to protect oneself against the effects of the overwhelming stress by raising the threshhold against the painful feelings evoked thereby" (p. 95).

The second stage is that of developing awareness where the reality of the death can no longer be ignored. The grieving person feels "empty" and often exhibits anger towards those around him and guilt which he manifests in

self-destructive acts. Typical of this phase is crying. Engel states: "In general, crying seems to involve both an acknowledgement of the loss and the regression to a more helpless and child-like status" (p. 95).

The third stage, restitution, is highly involved with various rituals which serve to emphasize the reality of the death. The gathering of the family, the funeral service, viewing of the body, and the graveside service are some rituals observed in Western culture which serve this purpose.

The final stage, resolution of the loss, is the intrapsychic portion of grief work. This stage spans the longest time period and involves a number of steps. The mourner attempts to deal with the emptiness that is felt, frequently by allowing himself to be dependent upon others. Bodily symptoms are sensed and are sometimes similar to those previously experienced by the deceased. The mourner finds himself intensely thinking and speaking about the deceased. Idealization of the deceased occurs. Positive attributes become magnified over negative characteristics. Slowly, the preoccupation with the dead person is lessened and the survivor begins to reinvest himself in new sources of gratification. The minimum time required for complete and successful grieving is one year (Engel 1964).

Lindemann (1963) lists seven stages of grief: (1) shock, (2) catharsis, (3) depression, (4) guilt,

(5) preoccupation with the loss, (6) anger, and (7) reality. Shock lasts for a few hours and is felt periodically during the following two weeks. Catharsis is the stage in which there is the release of emotion, with crying being the predominant form of emotional release. Lindemann believes crying is not essential to normal grief-work as long as the mourner is catharting in some manner. Depression is intensely felt during the first six months following the death and manifests itself in physical symptoms. Guilt and preoccupation with the deceased frequently occur simultaneously with depression. The extension of these stages for a lengthy time period may be a sign of a maladaptive grief reaction. Lindemann (1963) states that anger is a good and healthy sign. When the stage of reality is reached, a grieving person may still pass through any of the aforementioned stages intermittently for the next several years.

Pincus (1974) divides the process of mourning into an acute phase, controlled phase, and the phase of reality testing. The acute phase lasts only a few days and involves the response of shock which may be manifested in numbness, apathy, or overactive behavior. The controlled phase is the phase in which society dictates to the mourner the tasks that must be carried out. The mourner is surrounded by friends and relatives who help with burial and funeral arrangements. "He may literally feel that others will see to it that things

do not get out of control, that life goes on" (Pincus 1974 p. 115). The phase of reality testing encompasses a variety of behaviors. The first of these is searching for the lost person. Pincus (1974) states that this is an "almost automatic universal defense against accepting the reality of the loss" (p. 115). Alien behavior to the mourner such as anger, hostility, and self-hate may also be observed. Guilt about the mourner's relationship with the deceased may also be felt. Idealization and identification with the deceased may occur. The survivor may assume habits, interests, or physical symptoms of the deceased. Another phase of this final stage is that of regression which Pincus states is the most "painful and bewildering." "The bereaved may feel frightened and ashamed of the childish and irrational actions which neither he nor the people around him seem able to understand" (Pincus 1974 p. 122). Pincus believes there is no definite time limit for complete mourning and adaptation to the loss.

Westberg (1962) lists ten stages of grief. They are: (1) state of shock, (2) expression of emotions, (3) feelings of depression and loneliness, (4) appearance of physical symptoms and distress, (5) panic, (6) guilt about the loss, (7) feelings of hostility and resentment, (8) inability to resume usual activities, (9) hope, and (10) affirmation of the reality of the loss. The stage of shock is a

"temporary anesthesia" and should not extend further than a few days. The expression of emotion is necessary for both men and women according to Westberg. He points out that depression is normal and the length of this stage will vary from weeks to months depending on the individual. The appearance of physical symptoms may be temporary or may last until stage ten is reached. The stage of panic occurs when the mourner begins to think he will never be "normal" again as a result of his inability to concentrate on anything except his loss.

Westberg (1962) distinguishes between normal guilt and neurotic guilt. Normal guilt is felt about things one did or things one did not do for the deceased while he was alive. Neurotic guilt is disproportionate guilt in relation to actual involvement in the situation. Westberg states that hostility and resentment are not healthy emotions but are a part of the normal grief process. Despite the gradual rise from depression, a mourner continues to experience difficulty in performing the activities of daily living. The stage of hope emerges as the individual begins to find certain experiences to be meaningful again. Westberg notes that in the final stage, the "struggle" is not over even though the mourner is able to affirm reality once more.

Switzer (1970) examines grief in relationship to the needs of the bereaved. The first need he identifies is the need to release negative emotions such as guilt, hostility,

hatred, and anger. The second need, affirmation of one's self arises from the negative emotions felt toward the deceased. The mourner feels badly about these reactions and demonstrates some form of self-punitive behavior. The result of this is a lowered self-esteem. The third need is "that of freeing one's self from bondage to the deceased, breaking the ties, removing of libido from the lost loved object" (p. 198). Switzer lists the fourth need as the resurrection of the deceased within the self of the bereaved. When this need has been fulfilled, the fifth need, the renewal of relationships, can be met. According to Switzer (1970) most of the task of readjustment takes place within three months.

Variables Affecting Grief

There are many factors which affect the progress of an individual's grief work. Engel (1964) states that the major determinant to successful grief is the importance of the deceased as a source of support and gratification. "The more dependent the relationship, the more difficult will be the task of resolving its loss" (Engel 1964 p. 96). Holmes and Rahe (1967) identify the death of a spouse as the single most critical event in one's life. The death of a close family member ranks fifth on the social readjustment scale of critical life events.

The age and social value of the lost one also has profound influence on the success of mourning (Engel 1964; Glaser and Strauss 1964; Kalish 1969; and Kubler-Ross 1969). People are valued in Western society on the basis of various social characteristics; notably age, education, skin color, occupation, and family status. The single most important of these characteristics is age. A composite of social characteristics formulates one's "social value" (Glaser and Strauss 1964). There appears to be a direct relationship in Western culture between the social value of the deceased and the degree of grief evoked. For example: The death of a child is viewed as being far more tragic than the death of an elderly person. A child holds a high degree of social value because he is a potential contributor to a family, an occupation, and society. The aged person has already made his contribution to society. The death of a middle-aged person provokes the greatest emotional reaction (Kalish 1969). This is due largely to the fact that persons in this age group are still "productive citizens" according to Western values. Also, there are usually several people who are dependent on this person for financial and emotional stability.

The age of the mourner also affects his ability to adapt to the loss of a loved one. The mourning child usually has more difficulty in the resolution of such a loss than does an adult (Engel 1964).

An unexpected death induces a more severe grief reaction (Hinton 1967; Engel 1964). When a death is more gradual, the family is allowed a period of anticipatory mourning (Kubler-Ross 1969). The type of illness a patient may have had also influences the survivor's grief reaction (Kubler-Ross 1969). When the illness is painful and prolonged, the death seems to be more readily accepted by the family as an end to the patient's suffering.

The mourner's individual coping abilities also affect his success at grief work. As the number of grief experiences he has encountered and resolved increases, he will be better able to cope with future grief situations (Engel 1964). The physical and psychological health of the mourner is also an important determinant in his ability to cope with the loss (Engel 1964).

The relationship of the mourner to the deceased is a factor in resolving the loss. Ambivalence toward the deceased or the presence of severe guilt feelings may also interfere with grief work (Engel 1964; and Hinton 1967).

Complications of Grief

Authorities who view grief as an illness cite multiple physical and psychological problems that are precipitated by grief as a foundation for their stand. Maddison and Raphael (1973) state:

> Sensations and behaviors quite readily characterized as illness exist--pain, tension, suffering, autonomic disturbances, insomnia, fatigue, apathy. This disrupted period of function added to this human travail would certainly suggest grounds for considering it pathological. (p. 237)

Krant (1975) lists illnesses such as coronary artery disease, peptic ulcers, ulcerative colitis, dermatitis and bronchial asthma as medical problems that are precipitated by grief.

It has been hypothesized that cancer may be precipitated by the stress of mourning. Schmale and Iker (1966) interviewed women in a New York hospital who were suspected of having cancer of the cervix before a diagnosis was established. Each woman was interviewed and on the basis that she had experienced a recent loss and was severely depressed, she was predicted to have a high chance of a malignancy. If no loss had been experienced, the chance of a malignancy was predicted to be low. Physical examination and establishment of a diagnosis proved Schmale and Iker to be correct in 75 percent of their predictions. However, Schmale (1973) does not believe grief is a disease itself. He states:

> Normal grief is not a disease but disease may occur during periods when a patient experiences feelings of helplessness or hopelessness and there is an increased somatic and psychic vulnerability. (p. 263)

A classic study by Parkes, Benjamin and Fitzgerald (1969) showed the mortality rate for men 55 years of age

and older, six months after the deaths of their wives to be 40 percent above the expected rate for married men of the same age. The most frequent causes of death in this group of widowers were coronary thrombosis, and other arteriosclerotic and degenerative heart diseases.

A similar study by Rees and Lutkins (1967) showed that 4.8 percent of bereaved close relatives died within the first year following the death of their loved one as compared with a 0.68 percent death rate for the non-bereaved control group. The greatest increase in the mortality rate occurred among widows and widowers. Rees and Lutkins also found that the risk of the survivor dying within one year was doubled if the family member had died in a hospital rather than at home. When the death was an outdoor accident, the bereaved ran a five times greater chance of dying within one year.

Parkes and Brown (1972) studied a group of young widows and widowers in Boston. Results showed that the bereaved widows and widowers experienced disturbances of sleep, weight and appetite loss, complained of restlessness, depression, and inability to make decisions, and increased their consumption of alcohol, tobacco, and tranquilizers. Admissions to the hospital during the first year of bereavement were more frequent than those of the control group.

To the contrary, the study done by Clayton (1974) showed there to be no difference in the one year mortality rate for widows and widowers as compared to a similar population. Despite a marked increase in the psychological and physical depressive symptoms this group of widowed spouses experienced, they did not show an increase in the number of doctor visits and hospitalizations nor an increase in the use of tranquilizers.

Abnormal Reactions to Grief

Abnormal grief reactions do occur. A pathological reaction may occur when the normal grief process is delayed, suppressed, or distorted (Buxbaum 1974; Lindemann 1963; Marshall 1969; and Switzer 1970). Such a reaction may also occur if the death is sudden or if there has been an ambivalent relationship with the deceased (Marshall 1969). The result is that the bereaved remains overinvested in the deceased (Buxbaum 1974).

Frequently, an absence of grief is socially viewed as "taking it remarkably well" (Marshall 1969; Reeves 1970). However, incomplete or suppressed grief may lead to chronic depression and eventually psychosis (Marshall 1969). A study by Paul and Grosser (1965) of 50 families with schizophrenic members and 25 families with one or more neurotic member, found that all these families held one common feature; "A maladaptive response to object loss."

Unresolved grief was the dynamic factor in all the disturbed families that were studied.

Inadequate mourning at an inappropriate time may lead to loss of self-esteem, self-accusation, and self-punishment which may be manifest in suicidal tendencies (Marshall 1969; Switzer 1970). A study by Bunch (1972) carried out in England found that a cross-section of persons who had recently lost a parent or their spouse had a suicide rate five times greater than the rate of a comparable group of the general population.

Klein and Blank (1969) categorized some complications of mourning. Affect block is a complication characterized by marked emotional rigidity for fear of "breaking down." Agitated depression is characterized by insomnia, agitation, tension, severe guilt, self-punitive behavior and even thoughts of suicide. Retarded depression is a complication characterized by chronic apathy and feelings of demoralization and of being overwhelmed. Elation is characterized by over-activity, expensive, often adventurous foolish behavior, in which no sense of the loss is exhibited.

Lindemann (1963) lists the characteristics of an abnormal grief response: (1) overactivity, (2) acquisition of symptoms belonging to the deceased, (3) development of medical problems such as allergies and ulcers, (4) alteration in relationships with friends and relatives, (5) exhibition

of furious hostility, (6) persisting loss of patterns of social interactions, (7) demonstration of agitated depression, and (8) performance of large amounts of activity that is detrimental to social or economic existence.

Reeves (1970) adds to this list some possible signs of inhibited grief. Such signs include (1) attempts to control conversation to avoid emotionally laden topics, (2) casual reference, if any at all, to the deceased, (3) failure to acknowledge religious needs, and (4) non-verbal cues such as white knuckles or a brittle smile.

Therapeutic Measures

The bereaved person in the hospital setting has many needs. Hampe (1975) identified and classified the needs of a grieving spouse in the hospital setting under two broad categories: (1) needs in relationship to the dying person, and (2) needs of the grieving person. The study indicates that a grieving spouse needs to (1) be with the dying mate, (2) be helpful to the dying mate, (3) be assured of the comfort of the mate, (4) be informed continuously of the mate's condition, and (5) be aware of the impending death. The population studied also listed the need (1) to ventilate emotions, (2) for support and comfort from family members, and (3) for acceptance and support from health professionals.

Who is able to meet the needs of the bereaved person in the hospital setting? A study by Hammons (1970) on twenty grieved widows identified the nurse as the single most helpful person in meeting the needs of grieving widows. The physician was found to be the second most helpful. Marshall (1969) believes it is the responsibility of the physician to meet the needs of the bereaved. Sweetzer (1975) and Reeves (1970) feel the chaplain is the only one in a hospital who is qualified and available to meet these needs. Taplin (1971) states: "Assistance in crises does not have to come from specially skilled professionals, the humanity of significant others may be sufficient and necessary" (p. 15).

Equally important to the issue of who is to help the bereaved is the issue of what must be done. Measures, both short term and long term have been identified which aid the grief-stricken in reaching a healthy adaptation to the loss.

Immediate measures cited as being therapeutic in the initial state of grief include:

1. Allowing the spouse to remain with the mate during the mate's dying moments

2. Assuring the spouse that everything possible was done to make the mate comfortable during the mate's dying moments

3. Allowing the spouse to view the body if the spouse so desires

4. Allowing and gently encouraging crying and emotional display

5. Putting your arm around the spouse or holding the spouse's hand

6. Calling the family minister or hospital chaplain on request

7. Allowing the family to carry out any religious or cultural rituals they desire

8. Helping the spouse with postmortem tasks such as notifying relatives of the death or calling the funeral home

9. Administering a prescribed sedative/tranquilizer to the spouse

10. Offering and/or bringing food or beverage to the spouse

11. Remaining with the spouse until the spouse left the hospital

12. Encouraging the spouse to verbalize feelings

13. Talking about the mate in a complimentary way

14. Sharing memories and anecdotes about the deceased with the spouse

15. When talking about the death, use words which clearly establish the reality of the death (i.e. avoiding

terms such as "passed on," "no longer with us," "gone to heaven," etc.)

16. Accepting expressions of hostility and/or anger and do not attempt to defend the medical personnel, or the hospital

17. Reassuring the spouse that feelings of disbelief, anger, guilt, or emptiness that the spouse might be experiencing are normal.

Remaining with the dying person is a strong need of grieving spouses (Hampe 1975). The twenty widows interviewed by Hammons (1970) indicated that allowing frequent visits with the mate while alive was a helpful intervention. Glaser and Strauss (1968) state that "separation (from the patient) would be more painful than participation in the dying" (p. 154). This time together is crucial for the grief work which begins the moment one learns of the impending death to procede. Kubler-Ross (1969) states that hospitals should provide special consideration in allowing families time together before the death for "If members of a family can share these emotions together, they will gradually face the reality of impending separation and come to an acceptance of it together" (p. 150). Glaser and Strauss (1968) stress that family members should only be allowed to actually witness the death if the patient is dying comfortably and the family members can confront the situation with composure.

Hampe (1975) studied grieving spouses in the hospital setting and listed one need of the grieving person as the need for assurance of the comfort of the dying person. Hampe states that it serves to reduce family members' guilt when they are assured that all is being done for the patient. Hammons (1970) agrees that nurses should "maintain or increase efforts to give excellent nursing care to dying patients" (p. 72).

The manner in which families are informed of the member's death is dictated by the suddenness of the death and the composure of the family. When the death is expected, the announcement is made with little ritual or explanation. However, if the death is sudden, the announcement is often "buffered" by the use of prewarnings such as "the patient has taken a turn for the worse," by ushering the family into a private room, or by telling a friend or distant relative to "break the news" (Glaser and Strauss (1968).

Once the death has occurred and the family members have been informed, remaining with the mourner(s) is crucial (Kubler-Ross 1969; Marshall 1969; Pincus 1974; and Wygant 1967). Sweetser (1975) states that frequently medical and nursing staff are occupied with preparation of the body and care of other patients and cannot remain with the bereaved. Thus, he sees this as the major task of

hospital chaplains. Sweetser (1975) states:

> What should be the approach to the newly bereaved? Hardly that telling them that God is good and loving when circumstances seem to be saying cruelly that such is not the case. Rather, it should be simply in terms of a ministry of presence. (p. 117)

A major recommendation by Hammons (1970) for nurses who work with the grieving spouse is to remain with the widow after the death and not attempt to "rush her from the hospital."

Viewing of the body is necessary in order for the survivors to face the reality of the death (Engel 1964; Glaser and Strauss 1968; Kübler-Ross 1974; and Marshall 1969). This seems especially necessary when the death has been sudden and unexpected. Glaser and Strauss (1968) state about the family:

> Yet precisely because they have not seen the patient during his dying, they are likely to need a last look after death to say goodbye and to recognize the reality of the death. They wish to see for themselves; they wish to come to terms with the 'mystic gap' between their kinsman alive and their kinsman suddenly and astoundingly dead. (p. 212-13)

Engel (1964) warns that the request for a post-death look should never be denied on grounds that the viewing may evoke emotional outbursts and disrupt hospital floor routine. He states:

> This need to take leave, to ask forgiveness, to touch, kiss, or caress the dying or dead loved one, to take a lock of hair, is of overwhelming importance to some and will not be requested by those for whom it will be disturbing. (p. 91)

Expression of emotions is a necessary element of the grief process (Kubler-Ross 1969; Kutscher 1971; Lindemann 1963; Marshall 1969; Pincus 1974; Reeves 1970; and Switzer 1970). If ventilation of emotion does not occur, severe physical and/or psychological problems may arise (Lindemann 1963; Reeves 1970; and Switzer 1970). A person may not express emotion because he may feel he must be stoic for the rest of the family (Kubler-Ross 1969) or he may perceive health care personnel scorn such display (Buxbaum 1975; Reeves 1970). Crying is the most common but not sole form of emotional expression in the initial grief stage (Engel 1964).

The studies by Hammons (1970) and Freihofer and Felton (1976) do not uphold the belief that crying is necessary and beneficial. Only 50 percent of the widows interviewed by Hammons (1970) indicated that crying had been helpful to them. Freihofer and Felton studied grieving family members and had their subjects to rank supportive nursing measures in the order of desirability. The results show that the measure "to encourage me to cry" was ranked fourth least desirable of the 88 nursing interventions used for a grieving person.

Touch is a nonverbal means of communication which is usually used in the Western culture to convey emotional messages. How one interprets touch depends on the individual's culture, relationship to the one who is touching, and the situation. Hein (1973) notes that touch can be a very therapeutic tool when verbal communication is halted. Barnett (1972) observed that "the greater the patient's sense of isolation and sensory deprivation, the greater his need for relatedness to others through touch."

Findings in the study by Freihofer and Felton (1976) contradict the notion that touch is desirable to a grieving person. Of the 88 supportive nursing measures ranked in order of desirability by the bereaved family members, the measure "to hold my hand" ranked 86th. The measure was ranked much higher in desirability by females than by males. Jourard (1971) notes the type or region of touch and social acceptability do vary among males and females in the Western culture.

Calling the family minister or hospital chaplain is another measure cited as being therapeutic in the initial state of grief (Glaser and Strauss 1968; Reeves 1970; and Sweetser 1975). Sweetser (1975) states: "...Bedside prayers, when meaningful for the bereaved help toward a sense of reality and acceptance of death as part of the life process" (p. 118). Hammons (1970) agrees on including

the clergyman or chaplain "when this is desired by the widow." Reeves (1970) in discussing the angry reactions that news of an unexpected death triggers, warns against the need for chaplains or ministers to speak of the "will of God."

> When people are seen under these conditions, the less said of religious preachment or reassurance, the better. In this period of anger or guilt, it is most inappropriate to talk of 'the will of God' let alone His love. (Reeves 1970 p. 369)

Engel (1964) recognizes the role of cultural, religious, and social customs of mourners in providing support for the grief-stricken. He emphasizes that mourners must be allowed to carry out these rituals even though these customs may be "strange or even abhorrent."

Hammons (1970) suggests that helping family members with the tasks that are required following the death of a loved one is very supportive. Hammons learned from the twenty grieved widows interviewed that practical help such as making phone calls to notify relatives and bringing food and beverages was greatly appreciated by the mourners. Kubler-Ross (1974) notes that when a death is sudden and the bereaved are in a severe state of shock and denial, practical help in making arrangements and meeting physical needs may be all that can be done at that time.

There is a major controversy among physicians and thanatologists on the issue of prescribing a sedative or

tranquilizer to a newly bereaved person. Gibson (1974) cites three measures to be carried out for a newly bereaved person; the first being to administer a gentle sedative. Some of the widows interviewed by Hammons (1970) stated that prescribing a sedative was one action performed by their physician that was helpful.

Other authorities are cautious in advising the use of sedatives. Maddison and Raphael state:

> Chemical agents may be used to increase repression, to sedate, to tranquilize. Inherent in all these is the danger that inhibition of the normal grieving process will occur and pathological outcomes...will result. In certain cases, however, where the grieving process threatens to overwhelm the ego, such treatment may be necessary. (p. 243)

Marshall (1969) agrees that light sedation may be necessary in the initial phase of mourning but that continued use will only prolong the grieving process. Buxbaum (1974) strongly opposes any use of tranquilizing or sedating agents. He states: "This utilization of drugs is offered as a substitute for, rather than as an adjunct to, therapeutic assistance" (p. 95).

Speaking about the mate and the death that has occurred is necessary in order to begin moving the grieving person from the stage of denial into sensing the reality of the situation. Discussing the death in clear, open terms, in a manner that is complimentary to the deceased and without groping for explanations is helpful.

Buxbaum (1974) and Kubler-Ross (1974) emphasize the need to use "straightforward language" when discussing a death with the bereaved. Buxbaum (1974) states: "Euphemisms for death are seldom kind to those who have to accept the fact that a loved one is now dead" (p. 96). He concludes that by using open, straightforward verbalizations, the reality of the death can be established and the acceptance of this reality is necessary for a healthy grief reaction.

In the study of twenty grieved widows, Hammons (1970) suggests that widows be allowed to cry and talk about the deceased husband. Hammons also suggests that those who are working with the grieving widow "talk about the husband in a complimentary way--reveal the esteem with which he was held" (p. 71). Kubler-Ross (1969) agrees that speaking about the deceased, sharing stories and memories is a supportive measure to the bereaved.

There seems to be a need to rationalize and find some meaning in the death of a loved one in order to console the bereaved. Most authorities agree that it is not necessary to justify the death (Buxbaum 1974; Kubler-Ross 1974; and Sweetser 1975). When the death is sudden, theological speculation on the reason for the death is highly inappropriate and may trigger a very angry and bitter response from the bereaved (Buxbaum 1974; Reeves 1970;

and Sweetser 1975). Therefore, it is more supportive to listen to the bereaved and not attempt to seek an answer for the death.

A newly grieved person may express a great amount of anger and hostility in the immediate grief state. Engel (1964) suggests that this behavior is often in response to the individual's own guilt and aggressiveness toward the dying person. Beachy (1967), Kubler-Ross (1974), and Engel (1964) agree that the mourner's anger is usually not directed at anyone around him and that the most effective manner in dealing with the anger is to accept it quietly and not attempt to defend the accusations. Wygant (1967) summarizes by stating:

> The helping person furnishes an opportunity for those who hurt to express their anger, their pain, their fears to someone who will accept them, someone who will not be devastated by the expressed feelings. (p. 576)

The release of such negative emotions such as anger, guilt, and hostility is necessary in order for grief work to proceed (Switzer 1970). Too often, these emotions appear in a disguised form. These negative feelings give rise to negative attitudes about oneself. It becomes essential to help the bereaved verbalize these feelings and then reassure him that these feelings are normal and expected; thus, serving to reestablish positive attitudes about himself (Buxbaum 1974; Marshall 1969; and Switzer 1970).

Summary

There are numerous supportive measures that can be used to comfort newly bereaved persons. Yet health care personnel continue to be ineffective in the management of the immediate grief situation. Factors which may contribute to this ineffectiveness include: cultural attitudes on death; lack of education about the emotional needs of the dying patient and his family; sex role behavior, and cure as the primary focus of the health professions. The process of grief, as described by various thanatologists, may be adaptive or maladaptive. Complications and severe abnormal reactions may occur. If successful resolution of grief is to be accomplished, health care personnel can not avoid involvement with the dying patient and his family. Active involvement in the grief situation, education in the grief process, and judicious use of therapeutic measures will help direct a bereaved person toward a healthy adaptation to the loss of the loved one.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

Introduction

This descriptive research study, based on the criteria established by Brown (1958) for such a study, was conducted for the purpose of determining whether female nurses used different therapeutic measures for new widows than they used for new widowers in the hospital setting. Permission to implement this study was received from the Human Rights Committee of Texas Woman's University (see appendix A). This chapter discusses the setting, population, development of the research tool, and the methods used in collecting and analyzing the data.

Setting

The setting for this study was a 500 bed, religious affiliated hospital in Central Texas. Written permission to allow registered nurses from the proposed institution to participate in the study was granted through the Office of the Director of Nursing (see appendix A). Data was collected on four medical-surgical units (gynecology, oncology, orthopedics, and general medicine) and on the

intensive and coronary care units. These units were chosen on the assumption that there was a higher incidence of death on these units and consequently the nurse was more likely to have encountered a newly widowed person in the immediate grief state.

Population

The sample for this study was derived from a population of registered nurses employed by the given hospital who volunteered to participate. Participation in the study required meeting the predetermined criteria: (1) The nurse must be female. (2) The nurse must be currently licensed to practice professional nursing in the State of Texas. (3) The nurse must have had at least one exposure within the last 12 months to dealing with a widow or a widower in the immediate grief state in the hospital. (4) The nurse must be able to comprehend and express herself in the English language.

Fifty-four nurses responded to the questionnaire. However, only 49 nurses met the predetermined criteria and were included in the final sample. Twenty-nine nurses responded to having last worked with a new widow while twenty nurses responded to having last encountered a new widower in the immediate grief state. Data was collected until the designated quota of at least 20 responses in each category was met.

Development of the Tool

In reviewing the literature, a tool suitable for this study was not located. Therefore, a questionnaire was developed to provide data on the observed difference of the female nurse's therapeutic interaction with widows and widowers in the immediate grief state.

The tool developed was a questionnaire with close-ended questions relating to the measures the nurse perceived therapeutic and used in working with a newly widowed person. This method was chosen because of its relative simplicity and because observation or interviewing would not have been feasible with a large sample (Treece and Treece 1973).

The instrument constructed was based on previous studies and statements in the literature concerning measures that are effective in the immediate grief state in helping the bereaved begin adjusting to the death of a loved one. A list of therapeutic measures cited in the literature and measures frequently observed being used by nurses was compiled. The questionnaire was then divided into two sections. The first section asked the nurse to identify from the list which measure(s) she used in last interacting with a widow or widower in the immediate grief state. In the second part of the questionnaire, the nurse was asked to identify from the same list the measure(s) she would ideally employ in the same situation.

Validation of this tool was necessary. Validity is determined if the data measures what it is supposed to measure (Abdellah and Levine 1965). Therefore, a panel of judges with expertise in the subject of grief was chosen to validate the research instrument. The following persons served on the panel:

(1) An Associate Hospital Chaplain, B.A., B.D., and M.A. in counseling with experience in counseling patients and their families in crisis situations

(2) A registered nurse, B.S., M.S., and Ph.D. in psychology who has conducted seminars on death and grief

(3) An M.D. in private practice with a specialty in hematology who has worked with many leukemia patients and their families.

After obtaining consent by telephone to participate on the panel, a letter explaining the study with a copy of the research proposal and proposed tool was mailed to each panel member. The panel member was asked to make comments and suggestions on the general format, instructions, and on the demographic data to be collected. The panel member was also asked to evaluate each item on the list of measures and to answer the following questions about each measure:

(1) Is this measure therapeutic for a newly widowed person in the immediate grief state?

(2) Should this measure be included in the research tool?

Not all the listed measures were identified as therapeutic but the panel members felt non-therapeutic measures should also be included as a possible choice to decrease some of the bias in the study. A measure was included in the tool if at least two panel members were in agreement to its inclusion.

A pilot study utilizing five registered nurses not associated with this study was conducted. This pretest was used to determine whether or not the instructions were clear and the questions understood. The time necessary to complete the questionnaire was determined to be approximately 10 minutes.

Results from the pilot study and suggestions made by the panel members resulted in some minor changes in the wording of the directions to the participants and in the re-ordering of measures in the questionnaire. All changes were made prior to the data collection.

The final questionnaire consisted of two sections, each containing thirty therapeutic and non-therapeutic measures and an open-ended question about measures for a newly widowed person. Questions requesting demographic data were also included (see appendix B).

Procedure for Collection of Data

Once permission from the proposed institution was granted for the research, a meeting of the head nurses from the chosen medical-surgical units and critical care units was scheduled. The major purpose of the meeting was to elicit cooperation for the study. A brief description of the study, the questionnaire to be used, and the manner of data collection were discussed with the head nurses. A date and time for administration of the questionnaire was coordinated with each head nurse.

The data was collected between April and June 1977. On the chosen date, the researcher presented the qualifications for participating in the study and instructions for completing the questionnaire at team conference. An adequate number of questionnaires were left at the nurses' station for completion by nurses who wished to participate in the study. Anonymity was maintained as the questionnaire was not signed or coded to identify a respondant. A marked envelope for the questionnaire was left on the unit and collected after a 48 hour period.

Treatment of Data

This study was concerned with determining which measures the nurse used in working with a new widow or new widower, which measures were perceived therapeutic and if there was a significant difference between these sets

of measures. Therefore, the nature of this study required the data collected to be submitted to descriptive statistical analysis.

Frequency distributions were determined by use of the McNemar test. This test was also used to identify measures that were either used but not perceived therapeutic or were perceived therapeutic but not used by the nurses questioned.

To determine if the difference in the frequency of the measures was significant, Chi square was used. As a test of significance, Chi square indicates how significant the difference is between the frequencies observed, and the frequencies expected (Glass and Stanley 1970). Chi square was used to compute the significance of the difference in frequency of each of the thirty measures in the widow category and of the thirty measures in the widower category.

In addition, the demographic data was analyzed to determine if certain variables of the sample studied could be correlated with the results of the questionnaire in any manner.

Summary

A descriptive study on measures the female nurse perceives therapeutic and uses with widows and widowers in the immediate grief state was conducted. The research

project was carried out in a 500 bed religious affiliated hospital in Dallas, Texas. The final sample consisted of forty-nine registered nurses. Twenty nurses had last worked with a new widower and twenty-nine nurses had last worked with a new widow. A questionnaire was developed, validated, and pretested for collection of data. Reliability of the tool could not be tested due to the limited size of the anticipated sample. The questionnaire was distributed to the nurses at team conference. The data collected was subjected to statistical analysis. Frequency distributions of the measures were determined and subjected to the McNemar test and to the Chi square test for determination of significance. Demographic characteristics of the sample were also collected. The results are presented in the following chapter.

CHAPTER IV

ANALYSIS OF DATA

Introduction

A descriptive study was conducted to determine which measures the female nurse perceives therapeutic and actually uses in working with widows and widowers in the immediate grief state. The findings of this study were analyzed to determine whether or not there was a difference between the measures perceived therapeutic and used with widows and the measures used for widowers. A questionnaire with close-ended statements was designed for collection of data. Simple frequencies were tabulated from the data and subjected to the McNemar and Chi Square test for significance. This chapter examines and interprets the findings of this study.

Description of the Sample

The sample population was composed of forty-nine female registered nurses employed in a large Central Texas hospital. Twenty-nine nurses responded to having last worked with a new widow and will be referred to as the widow response group while twenty nurses responded to having last encountered a new widower and will be referred to as the widower response group.

The age of the sample population varied widely (see table 1). The ages of the nurses ranged from under twenty-five years to sixty-five years. The majority of the nurses (68 percent) were thirty-four years or younger. The difference in the ages between the widow response group and the widower response group was not found to be significant.

TABLE 1

AGE OF THE SAMPLE

Age	A		B		C	
	Number	Percent	Number	Percent	Number	Percent
under 25	5	17	5	25	10	21
25-34	14	48	9	45	23	47
35-44	2	7	4	20	6	12
45-54	7	24	2	10	9	18
55-65	1	4	0	0	1	2
Total	29	100	20	100	49	100

A: Widow Response Group

B: Widower Response Group

C: Total Sample

Religious preference of this sample is shown in table 2. Fifty-five percent of the respondants were Protestant with the second largest percentage (23 percent)

being Catholic. Overall, there was very little difference between religious preference of the widow response group and widower response group except in the category labeled "Other" where the difference was notable.

TABLE 2

RELIGIOUS PREFERENCE OF THE SAMPLE

Religion	A		B		C	
	Number	Percent	Number	Percent	Number	Percent
Catholic	6	21	5	25	11	23
Jew	0	0	1	5	1	2
Protestant	18	62	9	45	27	55
Other	2	7	4	20	6	12
No Preference	3	10	1	5	4	8
Total	29	100	20	100	49	100

A: Widow Response Group

B: Widower Response Group

C: Total Sample

Over seventy-five percent of the sample was Caucasian (see table 3). The smallest percentage of the sample (four percent) was Latin American. Racial differences between the widow response group and widower response group were insignificant.

TABLE 3

RACE OF THE SAMPLE

Race	A		B		C	
	Number	Percent	Number	Percent	Number	Percent
Negro	3	10	1	5	4	8
Caucasian	20	69	18	90	38	78
Latin American	1	4	1	5	2	4
Other	5	17	0	0	5	10
Total	29	100	20	100	49	100

A: Widow Response Group

B: Widower Response Group

C: Total Sample

Marital status of the sample was ascertained in order to determine if personal identification with this variable might have effect on the nurses' response to the grieving spouse (see table 4). The largest percentage of the widow response group (52 percent) was married while the largest percentage of the widower response group (35 percent) was single. This difference, however, was not found to be statistically significant.

TABLE 4

MARITAL STATUS OF THE SAMPLE

Marital Status	A		B		C	
	Number	Percent	Number	Percent	Number	Percent
Single	6	21	7	35	13	27
Widowed	1	3	0	0	1	2
Separated	3	10	2	10	5	10
Divorced	4	14	5	25	9	18
Married	15	52	6	30	21	43
Total	29	100	20	100	49	100

A: Widow Response Group

B: Widower Response Group

C: Total Sample

The participants in this study were also asked whether or not they had experienced the loss by death of a close friend or relative in the last 12 months. Nine in the widow response group had experienced such a loss. Four in the widower response group stated they had lost a loved one. This difference between the two groups' responses was not found to be significant. Thus, any difference in the measures used for widows and measures used for widowers

could not be directly attributed to the nurses' personal identification with the marital status of the grieving spouse nor with the grief experience itself.

Therefore, despite numerical differences between the age, religious preference, race, and marital status of the widow response group and the widower response group, none of these differences were found to be statistically significant.

Quint (1967) studied the curricula of various nursing programs and concluded that a portion of the nurse's avoidance of the dying patient and grieving family resulted from ideas and practices that were reinforced in her nursing education. It was, therefore, important to determine the basic nursing education of the sample (see table 5). The nurses were almost equally divided among the three types of basic nursing programs.

The length of time since graduation was computed for each group of nurses (see table 6). The range between the widow response group (1-30 years) and the widower response group (1-32 years) did not vary greatly, but there was a major difference in the average number of years since graduation. The mean number of years since graduation for the widow response group was 10.6 years while the mean number of years for the widower response group was 7.5 years.

TABLE 5

BASIC NURSING PROGRAM OF THE SAMPLE

Nursing Program	A		B		C	
	Number	Percent	Number	Percent	Number	Percent
Baccalaureate	11	38	6	30	17	35
Diploma	11	38	6	30	17	35
Associate	7	24	8	40	15	30
Total	29	100	20	100	49	100

A: Widow Response Group

B: Widower Response Group

C: Total Sample

TABLE 6

YEARS SINCE GRADUATION OF THE SAMPLE

	Range	Mean	Standard Deviation
Widow Response Group	1-30 years	10.6	9.4
Widower Response Group	1-32 years	7.5	7.8
Total Sample	1-32 years	9.3	8.8

Each nurse was asked to state the highest degree she had earned. Thirty-nine percent of the nurses had a bachelors degree. The rest of the nurses in the sample had earned a lower level degree. No one in the sample had earned a masters or a doctorate degree.

The nurse respondant was also asked to state the approximate number of newly widowed persons in the immediate grief state she had encountered in the hospital setting within the last 12 months (see table 7). The responses varied greatly, ranging from one to a hundred such encounters with newly widowed persons. The average number of encounters with a newly widowed person for the widow response group was 10.9 while the average number for the widower response group was 10.0.

TABLE 7

ASSOCIATION OF THE SAMPLE WITH NEWLY WIDOWED PERSONS

	Range	Mean	Standard Deviation
Widow Group	1-100	10.9	19.2
Widower Group	1-40	10.0	11.6
Total Sample	1-100	10.5	16.4

Overall, there were more similarities than differences between the widow response group and widower response group. No significant differences were found between the age, race, religious preference, and marital status of the two groups. The majority of the nurses in the sample were thirty-four years or younger (68 percent), Protestant (55 percent), and Caucasian (78 percent). There was no significant difference in the educational background of the nurses in the widow response group and of the nurses in the widower response group with respect to basic nursing program and highest degree earned. The sample was almost evenly divided among the three types of basic nursing programs. However, there was a sizeable difference in the average number of years since graduation between the widow response group (10.6 years) and widower response group (7.5 years). Despite a wide range in the number of encounters the nurses had with newly grieved persons in the hospital setting within the last year, the average number of such encounters for the widow response group was very close to the average number for the widower response group.

Presentation of Findings

Frequencies were tabulated from the data collected to determine the percentages of the measures used and/or perceived therapeutic for working with widows and widowers in the immediate grief state. Measures which the majority

of nurses in each response group used and/or perceived therapeutic were identified (see appendix C).

Both therapeutic and non-therapeutic measures were included in the questionnaire. Some of the measures the majority of the nurses in both groups used and/or perceived therapeutic were measures that neither the literature nor the Panel of Experts cited as therapeutic.

Fifty-two percent of the widow response group and fifty-five percent of the widower response group perceived the measure "Reassuring the spouse that the mate was better off now that the mate was no longer suffering" as therapeutic. Two of the three panelists did not categorize this measure as therapeutic. Buxbaum (1974), Kubler-Ross (1974), and Sweetser (1975) agree that it is not appropriate to justify the death of a loved one in order to console the bereaved.

"Showing the spouse to private quarters where he could be alone" was perceived therapeutic by 65 percent of the widower response group. This directly contradicts what Hammons (1970) recommends following her study of twenty grieved widows. One of the major recommendations from her study was that the nurse remain with the widow after the death and not attempt to "rush her from the hospital." However, only a very small percentage of the widow response group (10 percent) and widower response group (20 percent) actually used this measure.

The last measure chosen by the nurses which was not identified by the Panel of Experts as therapeutic was "Providing a pamphlet or book on the grief process for the spouse." Fifty-five percent of the nurses in the widower response group perceived this measure to be therapeutic.

All other responses chosen by the majority of nurses were therapeutic measures. Five measures cited as therapeutic were neither used nor perceived as therapeutic by the majority of nurses in either group. These measures were:

(1) Sharing memories and anecdotes about the deceased with the spouse,

(2) Remaining with the spouse until the spouse's departure from the hospital,

(3) Allowing the family or spouse to carry out cultural rituals,

(4) Not attempting to explain or give a reason for the death, and

(5) Using words which clearly establish the reality of the death.

Hypotheses I, II, III, IV

The four hypotheses presented and tested in this study deal with the difference between measures perceived therapeutic and/or used by female registered nurses for

widows and widowers. The hypotheses were statistically tested by use of the McNemar and Chi Square tests.

Hypotheses I and II were tested by the non-parametric McNemar test. A fourfold table of frequencies to represent the first and second sets of responses about the same measure was compiled for each item of the questionnaire. Under the null hypothesis, there should be an even division between the number of nurses who perceived a measure to be therapeutic but did not use it and the number of nurses who used a measure but did not perceive it to be therapeutic (Siegel 1956).

Hypotheses III and IV were tested by the Chi Square test for significance. Chi Square was used to measure the expected frequency of widow and widower responses against the actual observed frequency. Thus, the significance of the difference between the frequency a measure was used and/or perceived therapeutic by the widow response group and the frequency the measure was used and/or perceived therapeutic by the widower response group could be determined.

Hypothesis I

The first hypothesis was:

H_1: There is no difference in measures the female nurse perceives therapeutic and the measures she actually uses in dealing with the widow in the immediate grief state.

The sample for testing this hypothesis came from 29 registered nurses who had most recently worked with a new widow. In general, more nurses responded that a measure was therapeutic than the number of nurses who actually used that measure (see table 8). In three cases, there were actually more nurses who used a measure than believed it was helpful.

TABLE 8

MEASURES USED AND PERCEIVED THERAPEUTIC FOR WIDOWS

Measure	Actually Used		Perceived Therapeutic		Level of Significance
	Number	Percentage	Number	Percentage	
1	20	60	20	69	*
2	5	17	14	48	.01
3	6	21	8	28	*
4	6	21	15	52	.01
5	14	48	15	52	*
6	1	3	6	21	*
7	21	72	24	83	*
8	14	48	19	66	*
9	0	0	6	21	*
10	19	66	21	72	*
11	5	17	9	31	*
12	26	90	22	76	*
13	10	34	6	21	*

TABLE 8--Continued

Measure	Actually Used		Perceived Therapeutic		Level of Significance
	Number	Percentage	Number	Percentage	
14	6	21	21	72	.01
15	17	59	15	52	*
16	3	10	12	41	.01
17	9	31	18	62	.05
18	0	0	1	3	*
19	2	7	10	34	.05
20	1	3	4	14	*
21	2	7	7	24	*
22	19	66	20	69	*
23	0	0	1	3	*
24	6	21	16	55	.01
25	3	10	19	66	.05
26	1	3	1	3	*
27	10	34	18	62	.05
28	2	7	13	45	.01
29	8	28	12	41	*
30	8	28	8	28	*

Ninety percent of the nurses called the chaplain or family minister but only seventy-six percent believed such an action was therapeutic. This same relationship of

responses was also observed with the measures "Allowing the family to carry out religious rites" and "Allowing and encouraging crying and emotional displays." However, the decrease in the number of nurses who believed a measure was therapeutic from the number who actually used the measure was insignificant.

The hypothesis that there is no difference in the measures perceived therapeutic and actually used was rejected at the .05 level of significance in ten out of thirty measures. In each of these ten cases, there was a significant increase in the number of nurses who perceived a measure to be therapeutic over the number of nurses who actually used the measure. These measures include:

(1) Offering a prescribed tranquilizer/ sedative to the spouse (measure 2)

(2) Reassuring the spouse that the mate was "better off" now that the mate was no longer suffering (measure 4)

(3) Reassuring the spouse that feelings of disbelief, anger, guilt, or emptiness that the spouse might be experiencing are normal (measure 14)

(4) Showing the spouse to private quarters where the spouse could be alone (measure 16)

(5) Talking about the deceased mate in a complimentary way (measure 17)

(6) Remaining with the spouse until the spouse left the hospital (measure 19)

(7) Not attempting to explain or give a reason for the death (measure 24)

(8) Notifying friends or relatives of the death for the spouse on request (measure 25)

(9) Encouraging the spouse to verbalize feelings (measure 27)

(10) Providing a book or pamphlet on the grief process (measure 28).

Three of the ten measures for which Hypothesis I was rejected are measures that are not considered therapeutic. Seventeen percent of the nurses offered the widow a sedative/tranquilizer, yet forty-eight percent of the nurses felt this measure might have been beneficial. This finding is in agreement with Gibson (1974) who believes such action is necessary. Other authorities (Buxbaum 1974; Maddison et al. 1973; and Marshall 1969) as well as the Panel of Experts for this study disagree with the usefulness of this measure. There was also a significant increase in the number of nurses who felt "Showing the spouse to private quarters" was

therapeutic over the number who used this measure. Such an increase could also be observed in the measure "Providing a book or pamphlet on the grief process for the spouse." It is interesting to note that all three of these non-therapeutic measures are actions which decrease or eliminate the nurse's contact with the grieving spouse.

Hypothesis II

In testing the second hypothesis, data was collected from 20 nurses who had last worked with a widower. The second hypothesis presented was:

> H_2: There is no difference in the measures the female nurse perceives therapeutic and the measures she actually uses in dealing with the widower in the immediate grief state.

Table 9 identifies measures the nurses used and perceived therapeutic in working with the new widower.

In all but three cases, there was an increase in the frequency with which a measure was perceived therapeutic over its actual usage. None of the differences in frequencies of these three measures is statistically significant.

TABLE 9

MEASURES USED AND PERCEIVED THERAPEUTIC FOR WIDOWERS

Measure	Actually Used		Perceived Therapeutic		Level of Significance
	Number	Percentage	Number	Percentage	
1	12	60	15	75	*
2	5	25	8	40	*
3	3	15	7	35	*
4	7	35	11	55	*
5	8	40	6	30	*
6	2	10	4	20	*
7	14	70	14	70	*
8	14	70	15	75	*
9	2	10	7	35	.10
10	13	65	18	90	.10
11	2	10	6	30	*
12	17	85	20	100	*
13	11	55	10	50	*
14	3	15	14	70	.01
15	7	35	8	40	*
16	4	20	13	65	.05
17	9	45	14	70	.10
18	1	5	3	15	*
19	3	15	9	45	.05
20	2	10	3	15	*

TABLE 9--Continued

Measure	Actually Used		Perceived Therapeutic		Level of Significance
	Number	Percentage	Number	Percentage	
21	4	20	6	30	*
22	4	20	10	50	.05
23	3	15	4	20	*
24	7	35	10	50	*
25	7	35	17	85	.01
26	0	0	2	10	*
27	4	20	15	75	.01
28	1	5	11	55	.01
29	5	25	11	55	.05
30	4	20	9	45	.10

The hypothesis was rejected in eight of thirty cases at the .05 level of significance. The measures that were perceived therapeutic with a significantly greater frequency than they were used are:

(1) Reassuring the spouse that feelings of disbelief, anger, guilt, or emptiness the spouse might be experiencing are normal (measure 14)

(2) Showing the spouse to private quarters where the spouse could

be alone (measure 16)

(3) Remaining with the spouse until the spouse left the hospital (measure 19)

(4) Putting an arm around the spouse or holding the spouse's hand (measure 22)

(5) Notifying friends or relatives of the death by request of the spouse (measure 25)

(6) Encouraging the spouse to verbalize feelings (measure 27)

(7) Providing a pamphlet or book on the grief process (measure 28)

(8) Accepting expressions of hostility and/or anger and realizing that this is a frequent reaction to the death of a loved one (measure 29)

In four additional cases, Hypothesis II could be rejected at the .10 level of significance.

Two measures for which a significant increase of perceived therapeutic responses over actually used responses was observed were non-therapeutic measures. Twenty percent of the nurses showed the widower to private quarters where he could be alone yet sixty-five percent of the nurses believed this measure might have been helpful. Providing

a book or pamphlet on the grief process was another non-therapeutic measure that was perceived therapeutic with greater frequency than it was used.

All remaining measures for which Hypothesis II was rejected are measures that are considered therapeutic. Again, it appears that the nurses know of measures that are therapeutic but use them less frequently.

Hypothesis III

Chi Square was used to test Hypothesis III which states:

> There is no difference in the measures the female nurse perceives therapeutic in dealing with the widow and the measures she perceives therapeutic in dealing with the widower in the immediate grief state.

Measures which were perceived therapeutic for widows and widowers are shown on table 10.

Hypothesis III was rejected in three out of thirty cases. In all cases, the measure for which the difference in the widow response group and the widower response group was significant, was a therapeutic measure. A significantly larger percentage of nurses who worked with widowers perceived "Calling the chaplain" (measure 12) and "allowing the family to carry out cultural and religious rites" (measures 13 and 23) as being therapeutic than did the nurses who worked with widows.

TABLE 10

MEASURES PERCEIVED THERAPEUTIC FOR WIDOWS AND WIDOWERS

Measure	Widows		Widowers		Level of Significance
	Number	Percentage	Number	Percentage	
1	20	60	15	75	*
2	14	48	8	40	*
3	8	28	7	35	*
4	15	52	11	55	*
5	15	52	6	30	.10
6	6	21	4	20	*
7	24	83	14	70	*
8	19	66	15	75	*
9	6	21	7	35	*
10	21	72	18	90	*
11	9	31	6	30	*
12	22	76	20	100	.01
13	6	21	10	50	.05
14	21	72	14	70	*
15	15	52	8	40	*
16	12	41	13	65	.10
17	18	62	14	70	*
18	1	3	3	15	*
19	10	34	9	45	*
20	4	14	3	15	*

TABLE 10--Continued

Measure	Widows		Widowers		Level of Significance
	Number	Percentage	Number	Percentage	
21	7	24	6	30	*
22	20	69	10	50	*
23	1	3	4	20	.05
24	16	55	10	50	*
25	19	66	17	85	*
26	1	3	2	10	*
27	18	62	15	75	*
28	13	45	11	55	*
29	12	41	11	55	*
30	8	28	9	45	*

Thus, very little statistical difference can be determined between measures the nurse perceives therapeutic for a widow and measures the nurse perceives therapeutic for a widower. It is interesting to note that the widower response group more frequently perceived the therapeutic measure as therapeutic than did the widow response group.

Hypothesis IV

The fourth hypothesis tested states:

H_4: There is no difference in the measures the female nurse uses in dealing with widows

and the measures she uses with the widowers in the immediate grief state.

This hypothesis was rejected at the .05 level of significance in only three of the thirty measures (see table 11). The measure "Putting an arm around the spouse or holding his/her hand" (measure 22) was significant at the .01 level. The results of this finding are in agreement with Jourard (1971) who observed a lesser degree of inter-sexual touch than intra-sexual touch in Western culture. The widower response group allowed the family to carry out cultural rituals with significantly greater frequency (measure 23). Nurses in the widower response group were also more likely to notify friends and relatives of the death for the spouse (measure 25) than were the nurses in the widow response group.

Measures perceived therapeutic and used for widows did not differ significantly from measures perceived therapeutic and used for widowers. The significant difference appears in what the nurse does and what she believes is therapeutic when working with either a widow or a widower. In all cases where a significant difference was determined, more nurses perceived a measure to be therapeutic than actually used the measure.

TABLE 11

MEASURES USED FOR WIDOWS AND WIDOWERS

Measure	Widow		Widower		Level of Significance
	Number	Frequency	Number	Frequency	
1	20	69	12	60	*
2	5	17	5	25	*
3	6	21	3	15	*
4	6	21	7	35	*
5	14	48	8	40	*
6	1	3	2	10	*
7	21	72	14	70	*
8	14	48	14	70	*
9	0	0	2	10	.10
10	19	66	13	65	*
11	5	17	2	10	*
12	26	90	17	85	*
13	10	34	11	55	*
14	6	21	3	15	*
15	17	59	7	35	*
16	3	10	4	20	*
17	9	31	9	45	*
18	0	0	1	5	*
19	2	7	3	15	*
20	1	3	2	10	*

TABLE 11--Continued

Measure	Widow		Widower		Level of Significance
	Number	Frequency	Number	Frequency	
21	2	7	4	20	*
22	19	66	4	20	.01
23	0	0	3	15	.05
24	6	21	7	35	*
25	3	10	7	35	.05
26	1	3	0	0	*
27	10	34	4	20	*
28	2	7	1	5	*
29	8	28	5	25	*
30	8	28	4	20	*

Summary of Findings

Data was collected from forty-nine registered nurses; twenty-nine of whom had most recently worked with a widow and twenty who had last worked with a widower in the immediate grief period. Measures which the nurses used and/or perceived therapeutic in working with widows and widowers were identified.

No significant differences in age, race, religion, marital status, or basic nursing program could be determined

between the widow response and widower response group. Four hypotheses were tested using the McNemar and Chi Square test of significance.

The first hypothesis of this study predicted that there would be no difference in the measures the nurse perceives therapeutic and the measures she actually uses with a widow in the immediate grief state. This hypothesis was rejected in ten out of thirty measures.

The second hypothesis tested the same data in the widower response group. The hypothesis was rejected at the .05 level of significance in eight measures and at the .10 level of significance in four measures.

Chi Square was used to test Hypothesis III which states that there is no difference in measures perceived therapeutic in working with widows and widowers. The third hypothesis was rejected in three out of thirty cases.

Hypothesis IV predicted there to be no difference in the measures used for widows and widowers. In only three measures out of thirty was the hypothesis rejected.

Minimal difference could be demonstrated in what the nurse did and believed to be helpful when working with widows and what was done and perceived therapeutic with widowers. The difference lies in what the nurse knows and what the nurse does in working with a grieving spouse. The

nurse perceives certain measures to be therapeutic but does not use them when working with both widows and widowers in the early grief state.

CHAPTER V

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This study was designed to identify measures female nurses perceive therapeutic and use when working with a widow or a widower in the immediate grief state and to determine if there is a difference in these measures. This chapter reviews background, methodology, and results from the study. Inferences have been drawn from the analyzed data. Modifications for nursing support of the newly grieved spouse are suggested and additional areas for research on this topic are presented.

Summary

The focus for death and dying has shifted from the home to the hospital; thus, isolating society from the dying person and the grieving family. With the greatest percentage of deaths occurring in the hospital, it is mandatory that the nurse becomes the central source for emotional support for the dying and grieved.

Studies previously done indicate that the nurse has much difficulty fulfilling the role of supporting the dying patient and the bereaved survivors. Cultural values

concerning death, personal fears and anxieties, traditional goals of the profession which view death as failure, lack of education about the grief process, and cultural sex roles are some reasons cited for this avoidance behavior.

Grief has been studied by numerous thanatologists who agree that postponement of grieving may lead to a maladaptive, pathological response. The degree of the grief response is affected by many factors; the single most important being the relationship of the deceased as a source of gratification for the bereaved. The death of one's spouse has been ranked as the most stressful of man's critical life events. Thus, when a person loses his spouse in the hospital setting, the nurse is faced with a challenging and decisive role.

Measures which help direct an individual toward eventual resolution of the loss are cited. Such measures include: (1) encouraging expression of the loss, (2) helping with post-mortem tasks and decisions, (3) meeting the physical needs of the bereaved, (4) surrounding the grief-stricken with significant others, (5) speaking of the deceased in a respectful manner, (6) accepting all expressions of grief, and (7) gently emphasizing the reality of the situation.

The instrument designed for data collection was a closed-ended questionnaire divided into two sections. Each section was comprised of thirty items relating to nursing

actions for a newly bereaved person. The questionnaire, developed by the researcher, was based on measures cited therapeutic in the literature and on observations of nursing actions. The proposed instrument was validated by a panel of experts. A pilot study was conducted prior to completion of the tool.

The research sample consisted of forty-nine female registered nurses who were employed in a large private hospital in Central Texas. Twenty-nine nurses had most recently encountered a new widow while twenty nurses had last worked with a widower in the immediate grief state. There were no significant differences between the widow response group and the widower response group with respect to age, race, religion, basic nursing program, highest degree earned, or recent loss by death of a close relative or friend.

Measures perceived therapeutic and/or utilized by the nurses were identified. The data was subjected to the McNemar and Chi Square tests for significance. Analysis of the data obtained indicated that both the widow response group and widower response group more frequently perceived a measure to be therapeutic than they used the measure. All measures used by the majority of nurses in both groups were therapeutic. However, some measures the nurses perceived therapeutic were non-supportive measures. No difference was found in the measures perceived therapeutic and/or used for

widows and in the measures for widowers. In only three cases was there a significant difference in what was done for widows and for widowers. The female nurses physically touched the widow more frequently than they did the widower. The nurses in the widower response group allowed the family to carry out cultural rituals and notified friends and relatives of the death significantly more often than did the nurses in the widow response group. There were therapeutic measures that were neither used nor perceived therapeutic by the majority of the nurses.

Conclusions

The analysis of the data obtained in this study was the basis from which the following conclusions were derived. Many findings of this study are in agreement with the literature.

There were supportive measures that were perceived therapeutic and used by only a very small percentage of the sample population. Good (1972) and Quint (1967) state that lack of education or training on the grief process causes health professionals to be ill-prepared in caring for the bereaved.

It is concluded that the participant nurses perceived a measure to be therapeutic with greater frequency than it was actually used. Thus, the nurses knew of measures that were helpful, but for various reasons, did

not use them. Some of the reasons proposed by the literature for such an avoidance include; Western culture's influences on attitude formation about death (Kubler-Ross 1969; Quint 1967; and Tillich 1959); personal fears of death (Choron 1964; Mervyn 1971; and Scott 1971); sex role patterning (Jourard 1964; and Shope 1975), and the strong emphasis of health care on cure (Beland 1970; Kubler-Ross 1969; and Quint 1967). Even though the nurses may have received training on supporting the bereaved, these other factors may have had a stronger influence on the nurses' behavior.

The sample of nurses tended to perceive therapeutic those measures which are considered supportive. Thus, the nurses, either due to past experience or previous training, were able to recognize from the questionnaire measures that were therapeutic.

A minimal difference was observed in measures that participant nurses perceived therapeutic for widows and measures perceived therapeutic for widowers. It appears that the nurses believe that what is supportive for males is also supportive for females. This is in apparent agreement with the literature where no distinction between therapeutic measures for males and therapeutic measures for females could be found.

The nurses who last worked with widowers in this study perceived measures which required little nursing

involvement as therapeutic with greater frequency than did the widow response nurses. The widower response group cited the measures "Calling the hospital chaplain or minister by request of the spouse"; "Allowing the family to carry out religious rites"; and "Allowing the family to carry out cultural rituals" as being therapeutic more often than did the nurses who last worked with widows.

It is also concluded that the participant nurses who worked with widows were more likely to use touch as a supportive measure while nurses who worked with widowers were more likely to use non-involvement measures such as notifying friends of the death to help the bereaved spouse. Thus, the widower response nurses not only perceived certain non-involvement measures as therapeutic but also used such measures with greater frequency than did the widow response nurses who were more inclined to use touch. This finding agrees with Jourard (1971) who studied social acceptability of touch between males and females. Overall, however, the nurses in the widow response group tended to use the same measures as the nurses in the widower response group.

The measures used by the majority of the nurses in this study for widows and widowers were therapeutic measures, thus, indicating the nurses were, in general, helpful to the newly bereaved spouses. This upholds

the finding by Hammons (1970) that the nurse was the most helpful person to the newly widowed person in the hospital immediately following the death of the mate.

Implications

The findings of this study present implications for the individual nurse, nursing education, nursing service, and other health professionals. Each nurse has ideas and values about death, dying and grief which result from an integration of her religion, education, culture, and life experiences. The nurse should evaluate the feelings that are evoked by death and grief and attempt to identify the elements that have contributed to the foundation of such attitudes.

The individual nurse should examine her comprehension of the grief process and her knowledge of measures that are supportive to the bereaved during each grief stage. The nurse needs to identify and study the position she assumes when a grief situation is encountered. Questioning herself about differences in measures used for males and females, young and old, and about the supportive value of each measure is necessary for the nurse to acknowledge her true role. The nurse should examine the effect of administrative policies of the institution of her employment on her behavior in grief situations as well as the influences of her religion, culture, education, sex role, and previous experiences with grief. She must evaluate her knowledge

about grief and therapeutic measures in respect to her actions. Upon introspection, the nurse will come to understand the discrepancy between her knowledge of helpful measures for a grieving person and what she actually does. Acknowledgement of this discrepancy and understanding the myriad of factors that lend to her behavior must occur in order that the bereavement crisis be managed more effectively.

Nursing education has profound influence on the formation of the nurse's attitudes about death and grief. Nursing programs should periodically re-evaluate their philosophy in relation to the nurse and her role with the dying and grieved. The curriculum should be reviewed to determine if the philosophy and objectives relating to death, dying, and grief are being met. Nursing educators should examine their attitudes and identify the means used for transference of these attitudes. Classroom instruction, explicit about the care of dying patients and their grieving families, should be provided for and required of each nursing student. Clinical experience allowing the student an opportunity to practice what has been learned should be provided. For to provide the theoretical instruction but not the experience to develop understanding and skill in bereavement crisis management merely serves to reinforce the nurse's avoidance behaviors. There will continue to be a discrepancy in what the nurse knows should be done to

help the bereaved person and what she actually does throughout her nursing career.

Since the majority of deaths occur in hospitals, the findings of this study also have implications for nursing services. The philosophy of the institution should be reviewed to determine the primary focus of the institution since the role of the nurse in any situation should be compatible with the institution's philosophy. The large proportion of deaths that now occur in the hospital necessitate the nurse to function not only in a recovery role but also in a supportive role for the dying patient and the grieving survivors.

It should also be the responsibility of nursing service to initiate programs on the management of the dying patient and the bereaved family since many of the nurses working in hospitals today graduated before such programs were implemented in their basic nursing education. Group discussions organized by nursing service can also provide an opportunity for nurses to share thoughts and feelings about their work with dying patients and the grieving family.

Implications from the findings of this study can also be extended to other health professionals who work with the dying patient and grieving survivors. It should be the goal of all health professions to provide care for the living and the dying. Just as health professions must cooperate with each other and coordinate their work to help the dying

to a peaceful death, so must they help the bereaved develop a healthy adaptation to the loss. They too, can be effective only if they understand the origin of their attitudes about death, have received adequate education on the grief process and its management, and if they have had opportunity to encounter grief situations and become actively involved in them.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. An investigation utilizing the same methodology be conducted employing a larger sample of nurses from a variety of hospitals.

2. An investigation be conducted to determine if there is a difference in what the nurse believes is helpful and what she actually does using a subjective-objective approach. Such an approach would require the researcher to observe the widow/widower interaction and note which measures are used, then to interview the nurse using an open-ended interview form following the interaction to determine what she perceives would have been ideal.

3. Further studies be conducted employing a sample of nurses who had recently worked with a widow and a widower in the immediate grief state. Modification of the research instrument would be required.

4. Further studies be conducted into specific, individual measures identified in this study that nurses use in the immediate grief state for widows and widowers.

5. An investigation be conducted to determine if there is a difference in the measures a male nurse perceives therapeutic and actually uses with widows and widowers in the immediate grief state.

6. An investigation be conducted to compare measures used by nurses in acute care settings and nurses in general medical-surgical areas.

7. An inquiry be conducted into the basic types of nursing education in relationship to the depth and manner that death, dying, and grief are taught.

8. An investigation be conducted employing an equal number of graduate nurses from baccalaureate, associate, and diploma programs to determine if there is a correlation between a nurse's basic nursing program and the discrepancy in what the nurse perceives therapeutic and actually does for a newly widowed person.

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APPENDIX A

TEXAS WOMAN'S UNIVERSITY
DALLAS, TEXAS 75235

COLLEGE OF NURSING

August 3, 1976

Ms. Rebecca Ragland Cherry
1519 Estates
Carrollton, Texas 75006

Dear Ms. Cherry:

As a recently appointed member of the Human Research Review Committee, Dallas Center, I have read and approved your proposed protocol for research entitled, "Therapeutic Measures for Surviving Spouses".

Please continue with your plans for collection of data.

Sincerely,

Tommie R. Wallace

Tommie R. Wallace, R.N., M.S.
Assistant Professor, Coordinator
Graduate Maternal-Child Health Nursing

TRW:rw

OFFICE OF THE ASSOCIATE DEAN
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Houston, Texas 77025

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Methodist Hospital of Dallas

GRANTS TO Rebecca J. Cherry

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To determine whether or not there is a difference in measures the female nurse perceives as therapeutic and actually uses in dealing with the widow and the widower in the immediate grief state

The conditions mutually agreed upon are as follows:

1. The agency (may) (~~may not~~) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date 8/12/76

Signature of Agency Personnel

Rebecca J. Cherry
Signature of Student

Lois Hough/
Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original -- Student; first copy -- agency; second copy -- T.W.U. College of Nursing.

APPENDIX B

INSTRUCTIONS

This study is designed to determine what measures you feel are helpful in working with a new widow or widower in the immediate grief period. If you are a female RN, licensed in the state of Texas, and have had at least one exposure within the last 12 months to a person who has just experienced the death of his/her spouse in the hospital, your help in filling out this questionnaire will be greatly appreciated. The first part of this research tool is to obtain some information about you. Please do not put your name on this questionnaire. Simply circle the appropriate letter or fill in the blank as required. The second part consists of two brief checklists. The approximate time needed to complete this questionnaire will be 10 minutes. Place the completed questionnaire in the marked envelope. Thank you.

DIRECTIONS: Please circle the response that best describes you.

I. Religious preference:
1. Catholic
2. Jew
3. Protestant
4. Other
5. No Prefernece

II. Race:
1. Negro American
2. Caucasian
3. Latin American
4. Other

III. Age:
1. 55-65
2. 45-54
3. 35-44
4. 25-34
5. under 25

IV. Present Marital Status:
1. Single (never married)
2. Widowed
3. Separated
4. Divorced
5. Married

V. Highest degree earned:
1. Doctorate
2. Masters
3. Baccalaureate
4. Associate
5. High School

VI. Basic Nursing Program:
1. Baccalaureate
2. Diploma
3. Associate

DIRECTIONS: Please fill in the blank.

VII. Date of graduation from basic nursing program _____.

VIII. Year became licensed as an RN _____.

IX. List the areas in nursing in which you feel competent or have had special experience:

Area	# years in this area

X. Approximate number of grieving spouses with whom you have had contact in the hospital in the last 12 months _____.

XI. Have you experience the loss of a close friend or relative within the last 12 months? _____

XII. The last interaction you had with a grieving spouse in the hospital immediately following the death of the patient was with a: (please circle)

1. Widow (wife)
2. Widower (husband)

DEFINITIONS

These definitions are provided to help clarify the following questions. Please refer to them if a question is unclear.

Widow: A wife who has just experienced the death of her present husband

Widower: A husband who has just experienced the death of his present wife

Spouse: The surviving husband or wife

Mate: The partner that is deceased

PART II A

DIRECTIONS: Recall the last situation in which you worked with a widow or widower immediately following the death of the mate in the hospital. Please circle the measure(s) you used in working with this person.

1. Assured the spouse that all possible was done to make the mate comfortable during the mate's dying moments.
2. Offered a prescribed tranquilizer/sedative to the spouse.
3. Gently ushered the spouse from the room when the mate's condition worsened and death was imminent.
4. Reassured the spouse that the mate was "better off" now that the mate was no longer suffering.
5. Allowed the spouse to remain with the mate during the mate's dying moments.
6. Avoided mention of the deceased mate so as not to upset the spouse.
7. Listened quietly to what the spouse said
8. Allowed the spouse to view the body if the spouse so desired.
9. Shared memories and anecdotes about the deceased with the spouse.
10. Offered and/or brought food and beverage to the spouse.
11. Broke the news of the death gently by using the term "gone to heaven", or "no longer with us", or a similar term.
12. Called the family minister or hospital chaplain on request of the spouse.
13. Allowed the family to carry out special religious rites.
14. Reassured the spouse that feelings of disbelief, anger, guilt, or emptiness that the spouse might be experiencing are normal.
15. Allowed and gently encouraged crying and emotional displays.
16. Showed the spouse to private quarters where the spouse

could be alone.

17. Talked about the deceased mate in a complimentary way.

18. Quickly covered the body of the mate so as not to upset the spouse.

19. Remained with the spouse until the spouse left the hospital.

20. Justified actions of health care personnel or the hospital when the spouse suggested the mate had received inadequate care.

21. Helped the spouse remain in control by softly urging the spouse to not cry.

22. Put your arm around the spouse or held the spouse's hand.

23. Allowed the family or spouse to carry out any cultural rituals they desired.

24. Did not attempt to explain or give a reason for the death.

25. Notified friends or relatives of the death for the spouse on request.

26. Tactfully advised the family to perform religious or cultural rituals elsewhere so not to disturb other patients.

27. Encouraged the spouse to verbalize feelings.

28. Provided a pamphlet or book on the grief process for the spouse.

29. Accepted expressions of hostility and/or anger and realized that this is a frequent reaction to the death of a loved one.

30. When talking about the death, used words which clearly established the reality of the death. (ie. Avoided terms such as "passed away" or "gone to the angels.")

31. Other: As a nurse, you may have found measures that are helpful to a newly widowed person. If you used a measure that does not appear on this list, it would be of great value to the researcher for you to share it. Please use the back if necessary.

PART II - B

DIRECTIONS: In looking at this same situation you just recalled, what do you think would have been ideal for you to have done? Please circle the measure(s) you feel would have been ideal to have used. If you think something you did was ideal, circle it also.

1. Allowed the family or spouse to carry out any cultural rituals they desired.

2. Helped the spouse remain in control by softly urging the spouse not to cry.

3. Justified actions of health care personnel or the hospital when the spouse suggested the mate had received inadequate care.

4. Notified friends or relatives of the death for the spouse on request.

5. Provided a pamphlet or book on the grief process for the spouse.

6. Allowed and gently encouraged crying and emotional displays.

7. When talking about the death, used words which clearly established the reality of the death. (ie. Avoided terms such as "passed away", or "gone to the angels".)

8. Avoided mention of the deceased mate so as not to upset the spouse.

9. Allowed the spouse to view the body if the spouse so desired.

10. Reassured the spouse that feelings of disbelief, anger, guilt, or emptiness that the spouse might be experiencing are normal.

11. Talked about the deceased mate in a complimentary way.

12. Shared memories and anecdotes about the deceased mate with the spouse.

13. Gently ushered the spouse from the room when the mate's condition worsened and death was imminent.

14. Offered a prescribed tranquilizer/sedative to the spouse.

15. Showed the spouse to private quarters where the spouse could be alone.

16. Put your arm around the spouse or held the spouse's hand.

17. Quickly covered the body of the mate so as not to disturb the spouse.

18. Offered and/or brought food and beverage to the spouse.

19. Reassured the spouse that the mate was 'better off" now that the mate was no longer suffering.

20. Broke the news of the death gently by using the term "gone to heaven", "no longer with us", or a similar term.

21. Tactfully advised the family to perform religious or cultural rituals elsewhere so not to disturb other patients.

22. Remained with the spouse until the spouse left the hospital.

23. Encouraged the spouse to verbalize feelings.

24. Did not attempt to explain or give a reason for the death.

25. Assured the spouse that all possible was done to make the mate comfortable during the mate's dying moments.

26. Accepted expressions of hostility and/or anger and realized that this is a frequent reaction to the death of a loved one.

27. Called the family minister or hospital chaplain on request of the spouse.

28. Listened quietly to what the spouse said.

29. Allowed the family to carry out special religious rites.

30. Allowed the spouse to remain with the mate during the mate's dying moments.

31. Other: Are there any other measures you feel might have been helpful that do not appear on this list? If so, please list them. Use the back if necessary.

APPENDIX C

MEASURES MAJORITY OF NURSES USED

AND PERCEIVED THERAPEUTIC

FOR WIDOWS AND WIDOWERS

MEASURE	USED		PERCEIVED THERAPEUTIC	
	WIDOW	WIDOWER	WIDOW	WIDOWER
1. Assured the spouse that all possible was done to make the mate comfortable during the mate's dying moments. *	yes	yes	yes	yes
2. Offered a prescribed tranquilizer/sedative to the spouse.				
3. Gently ushered the spouse from the room when the mate's condition worsened and death was imminent.				
4. Reassured the spouse that the mate was "better off" now that the mate was no longer suffering.			yes	yes
5. Allowed the spouse to remain with the mate during the mate's dying moments. *			yes	yes
6. Avoided mention of the deceased mate so as not to upset the spouse.				
7. Listened quietly to what the spouse said. *	yes	yes	yes	yes
8. Allowed the spouse to view the body if the spouse so desired. *		yes		yes
9. Shared memories and anecdotes about the deceased with the spouse. *				

MEASURE	USED		PERCEIVED THERAPEUTIC	
	WIDOW	WIDOWER	WIDOW	WIDOWER
10. Offered and/or brought food and beverage to the spouse. *	yes	yes	yes	yes
11. Broke the news of the death gently by using the term "gone to heaven," or "no longer with us," or a similar term.				
12. Called the family minister or hospital chaplain on request of the spouse. *	yes	yes	yes	yes
13. Allowed the family to carry out special religious rites. *		yes		
14. Reassured the spouse that feelings of disbelief, anger, guilt, or emptiness that the spouse might be experiencing are normal. *			yes	yes
15. Allowed and gently encouraged crying and emotional displays. *	yes		yes	
16. Showed the spouse to private quarters where the spouse could be alone.				yes
17. Talked about the deceased mate in a complimentary way. *			yes	yes
18. Quickly covered the body of the mate so as not to upset the spouse.				
19. Remained with the spouse until the spouse left the hospital. *				

MEASURE	USED		PERCEIVED THERAPEUTIC	
	WIDOW	WIDOWER	WIDOW	WIDOWER
20. Justified actions of health care personnel or the hospital when the spouse suggested the mate had received inadequate care.				
21. Helped the spouse remain in control by softly urging the spouse to not cry.				
22. Put your arm around the spouse or held the spouse's hand. *	yes		yes	
23. Allowed the family or spouse to carry out any cultural rituals they desired. *				
24. Did not attempt to explain or give a reason for the death. *				
25. Notified friends or relatives of the death for the spouse on request. *			yes	yes
26. Tactfully advised the family to perform religious or cultural rituals elsewhere so not to disturb other patients.				
27. Encouraged the spouse to verbalize feelings. *			yes	yes
28. Provided a pamphlet or book on the grief process for the spouse.				yes

MEASURE	USED		PERCEIVED THERAPEUTIC	
	WIDOW	WIDOWER	WIDOW	WIDOWER
29. Accepted expressions of hostility and/or anger and realized that this is a frequent reaction to the death of a loved one. *				yes
30. When talking about the death, used words which clearly established the reality of the death. (i.e. Avoided terms such as "passed away" or "gone to the angels.") *				

*Therapeutic Measures